



**Texas Department of Insurance**  
**Division of Workers' Compensation**  
Medical Fee Dispute Resolution, MS-48  
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### PART I: GENERAL INFORMATION

Requestor Name and Address:  HARRIS METHODIST HEB 3255 W PIONEER PKWY ARLINGTON TX 76013-6013	MFDR Tracking #: M4-07-7471-01  DWC Claim #:  Injured Employee:
Respondent Name and Carrier's Austin Representative Box #:  LUMBERMENS MUTUAL CASUALTY CO. Box #: 21	Date of Injury:  Employer Name:  Insurance Carrier #:

### PART II: REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Understanding that TWCC is wanting to move to a hospital reimbursement of a %-over-Medicare, we have used this methodology in our calculation of fair and reasonable... Medicare allows \$294.94 on CPT 72131, \$142.78 on CPT 76376, and allowing these at 125% would yield a fair and reasonable allowance of \$547.16"

**Amount in Dispute:** \$317.79

### PART III: RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Respondent timely and properly audited and disputed the charges made the basis of this dispute. The amount of reimbursement paid by the Respondent was a fair and reasonable reimbursement... In addition, Respondent adjusted payment because there existed a claim specific negotiated discount."

**Response Submitted by:** Thornton, Biechlin, Segrato, Reynolds & Guerra, L.C., 912 S. Capital of Texas Highway, Suite 300, Austin, Texas 78746-5242

### PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
11/10/2006	147, 131, S01, 42	Outpatient Surgery	\$317.79	\$0.00
<b>Total Due:</b>				\$0.00

### PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code § 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Medical Reimbursement*, effective May 2, 2006 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on July 19, 2007.

- For the services involved in this dispute, the respondent reduced or denied payment with reason code:
  - 147 – Provider contracted/negotiated rate expired or not on file.
  - 131 – Claim specific negotiated discount.
  - S01 – Pursuant to Texas Labor Code 413.011 and other applicable statutes this bill has been reviewed to a standard of reasonableness based on current industry benchmarks of typical reimbursement for comparable services in your geographical area.
  - 42 – Charges exceed our fee schedule or maximum allowable amount.
- The carrier has denied or reduced payment based on denial reason "131 – Claim specific negotiated discount." No documentation was found to support a contractual agreement between the parties to this dispute. No documentation was found to support a claim specific negotiated discount for the services in dispute. Review of the submitted documentation finds that this denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

3. This dispute relates to outpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 2, 2006, 31 TexReg 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. Division rule at 28 TAC §133.307(c)(2)(G), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
  - The requestor's position statement asserts that "Understanding that TWCC is wanting to move to a hospital reimbursement of a %-over-Medicare, we have used this methodology in our calculation of fair and reasonable... Medicare allows \$294.94 on CPT 72131, \$142.78 on CPT 76376, and allowing these at 125% would yield a fair and reasonable allowance of \$547.16"
  - The fee guidelines as adopted in Division rule at 28 TAC §134.403 were not in effect during the time period when the disputed services were rendered.
  - While the Division has previously found that Medicare patients are of an equivalent standard of living to workers' compensation patients, (22 TexReg 6284, July 4, 1997), Texas Labor Code Section 413.011(b) requires that "In determining the appropriate fees, the commissioner shall also develop one or more conversion factors or other payment adjustment factors taking into account economic indicators in health care and the requirements of Subsection (d)... This section does not adopt the Medicare fee schedule, and the commissioner may not adopt conversion factors or other payment adjustment factors based solely on those factors as developed by the federal Centers for Medicare and Medicaid Services."
  - The requestor did not discuss or present documentation to support how payment of 125% of the Medicare allowable would provide fair and reasonable reimbursement for the disputed services during the time period that treatment was rendered to the injured worker.
  - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
  - The requestor did not submit nationally recognized published studies, published Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
  - The requestor did not discuss or explain how payment of the requested amount would satisfy the requirements of Division rule at 28 TAC §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

6. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(c)(2)(A) and §133.307(c)(2)(G). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

## **PART VI: GENERAL PAYMENT POLICIES/REFERENCES**

Texas Labor Code §413.011(a-d), §413.031 and §413.0311  
28 Texas Administrative Code §133.307, §134.1, §134.403  
Texas Government Code, Chapter 2001, Subchapter G

## PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

### DECISION:

**Grayson Richardson**

**7/27/2011**

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
Date

## PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**